September 2, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 [CMS-1631-P]

Dear Acting Administrator Slavitt:

The American Academy of Neurology (AAN) is the premier national medical specialty society representing more than 28,000 neurologists and clinical neuroscience professionals and is dedicated to promoting the highest patient-centered quality neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system such as Alzheimer’s disease, stroke, epilepsy, Parkinson’s disease, migraine, multiple sclerosis, and brain injury.

The AAN appreciates the opportunity to offer comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Proposed Rule entitled Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 [CMS-1631-P].

This letter includes the AAN’s recommendations, comments, and questions regarding the following provisions of the Proposed Rule:

- Payment Accuracy for Primary Care and Care Management Services
- Payment for the Professional Work of Care Management Services
- Establishing Separate Payment for Collaborative Care
- CCM and TCM Services
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Low-volume Thresholds
- Clinical Practice Improvement Activities
- Alternative Payment Models
- Improving the Valuation and Coding of the Global Package
- Advance Care Planning Services
- Refinement Panel
- Clinical Labor Task: Complete Botox Log
- Valuation of Specific Codes: Vestibular Caloric Irrigation
I. Improving Payment Accuracy for Primary Care and Care Management Services

The AAN believes evaluation and management (E/M) services should be valued so that every provider, regardless of specialty, is offered an added incentive to spend appropriate time with patients, rather than engaging in procedures. We strongly support CMS for recognizing care management as critical to helping individuals achieve better health outcomes and reducing expenditure growth. We commend the agency for proposing to address the deficiencies in the existing E/M services, especially as they relate to the delivery of comprehensive, coordinated care management.

A. Improved Payment for the Professional Work of Care Management Services

The AAN supports CMS’ proposal to create add-on codes to recognize and reimburse the physician work associated with E/M services.

CPT Code 90785 details added interactive complexity in psychotherapy. We recommend four (4) new add-on codes for use by all specialties. One code would describe higher intensity service during an E/M visit with a new patient, and a second code for higher intensity service with an established patient. Two more codes would describe even higher levels of intensity for E/M visits with new and established patients. We are prepared to suggest appropriate corresponding vignettes.

Current E/M codes were developed 30 years ago. They do not adequately describe the range of work in current E/M visits. Visit intensity is now higher, and in some cases much higher, than it was 30 years ago for patients requiring chronic care coordination. Often these patients have more severe illnesses and a significant number of active medical diagnoses. They are also completing multiple treatments that interact and need coordination of services from multiple providers. The complexity of medical decision making is higher than recognized for level 5 E/M services and often is much higher. Complex care patients also need greater pre- and post-service physician work, and there are significant practice expenses to provide these much needed services.

The fair valuation of E/M services is the most important Medicare fee-for-service issue for neurologists and our patients. About 20 percent of neurologists perform no procedures, and for 2/3 of neurologists, E/M constitutes more than 60 percent of billed services. Careful and complex medical decision making can reduce unnecessary testing, control medical
expense, and improve the patient experience. Correct E/M reimbursement is also key to fairly recognize neurologist work in ACOs and under alternative payment models (APMs).\textsuperscript{1,2}

**We support CMS initiatives to improve the evidence base of work intensity and time duration for medical services as they evolve.** A University of Cincinnati group, sponsored by the AAN and other medical specialty societies, has explored the use of validated alternative methodologies to the RUC methodology (NASA Task Load Index, Subjective Work Assessment Technique, Dundee Stress State Questionnaire) and performed immediately after a patient encounter.\textsuperscript{3,4,5} These peer-reviewed publications establish that methods used to measure work intensity in non-medical fields are valid for measuring physician work intensity. In these studies, surgeons and non-procedural physicians reported similar work intensity for surgery and office visits when asked immediately after performing a surgical procedure and finishing clinic. **Based on these findings, the AAN requests that CMS perform more comprehensive research on the relative intensity of E/M, surgical services, and medical procedures and imaging, for the purpose of assigning correct relative valuation.**

A recent analysis of the Medicare Physician Fee Schedule (MPFS) found that 89 percent of the value of physician work is accounted for by time alone. Discrepancies in physician income suggest, however, that CMS’ accepted duration for physician services may not be accurate.\textsuperscript{6} The Medicare Payment Advisory Commission (MedPAC) is similarly concerned that times for physician services are not uniformly accurate in the Fee Schedule.\textsuperscript{7} A recent report by the RAND Corporation questions the accuracy of intraservice times assigned to surgical procedures.\textsuperscript{8} **We support CMS’ efforts to measure, rather than estimate, actual times for physician services, including measuring the number of services provided in the postoperative global periods for surgical services.**

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\textsuperscript{1} Skolarus, LE; Burke, JF; Callaghan, BC; Becker, A; Kerber, KA. “Medicare Payments to the Neurology Workforce in 2012.” *Neurology.* 84 (2015): 1796–1802.


\textsuperscript{4} Id. at 108-113.


\textsuperscript{8} Wynn, Barbara O; et al. “Development of a Model for the Validation of Work Relative Value Units for the Medicare Physician Fee Schedule.” *RAND Corporation.* 2015. [http://www.rand.org/pubs/research_reports/RR662]
The AAN has consistently asserted the need to measure, rather than estimate, actual times for physician services. In March 2015, the AAN co-signed a joint letter with societies representing internal medicine; family medicine; allergy, asthma, and immunology; rheumatology; gastroenterology; hematology; endocrinology; and psychiatry. Our letter to CMS Deputy Administrator Sean Cavanaugh recommended the following:

- We believe that new codes must be developed from a knowledge-base that reflects the current levels of outpatient E/M physician work based on nationally representative samples and electronically accessible data.
- Codes must define clear, discrete, and graded increments of physician work intensity.
- New codes should also include documentation expectations that focus on medical decision making.

The AAN further encourages CMS to do the following:

- Develop G codes to allow physicians to describe and bill for the added time, intensity, and practice expense in caring for complex chronically ill patients, until CPT and RUC can develop a potentially more robust solution.
- We also encourage CMS to develop G codes to describe newer formats for interprofessional consultation services while CPT and RUC consider other coding solutions.

We also ask that CMS commit to hiring a contractor to work with stakeholders like the AAN to develop a comprehensive understanding of what physicians and their clinical staff do on a daily basis. This research would:

- Describe in detail the full range of intensity for outpatient E/M services.
- Define discrete levels of service intensity based on this observational and electronically stored data combined with expert opinion.
- Develop documentation expectations for each service level that place a premium on the assessment of data and resulting medical decision making.
- Provide efficient and meaningful guidance for documentation and auditing.
- Ensure accurate relative valuation as part of the MPFS.

We expect this work could be completed in time for these services to be proposed and valued for inclusion in the CY 2018 MPFS.

**B. Establishing Separate Payment for Collaborative Care**

Chronic care management (CCM) services are designed to recognize non-face-to-face care. These services require the following elements:

- At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
Comprehensive care plan established, implemented, revised, or monitored.9

There are clinical situations lacking one or more of these required elements, in which patients still need and benefit from similar services. Examples include patients with a single chronic disorder, such as primary progressive multiple sclerosis, or rapidly progressive dementia. Another example is a patient that may be expected to recover within 12 months, such as acute bacterial endocarditis or Guillain-Barre syndrome.

The AAN therefore requests that CMS establish add-on codes for use with E/M services other than CCM.

First, we request the following add-on codes that, in parallel with CCM codes, require at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month for services below:

- Comprehensive care plan established, implemented, revised, or monitored.
- Medication reconciliation with review of adherence and potential interactions.
- Oversight of patient self-management of medications.
- Manage care transitions between and among health care providers and settings, including referrals to other providers.
- Coordinate care with home and community-based clinical service providers.

We note that shorter time for these services is included in the postservice work of E/M, but these services may require a greater deal of time and attention during any potential visit.

Second, we request that CMS develop or encourage codes to recognize the increasing complexity of E/M services, similar to CPT Code 90785 for added interactive complexity in psychotherapy. These codes would be billed as add-on codes for E/M visits with new and established patients. The following describes these factors:

- Added complexity of medical decision making: Patient with higher complexity of medical decision making, such as a patient with 6 or more chronic conditions expected to last at least 12 months, or a patient on 6 or more chronic medications.
- Further added complexity of medical decision making: Patient with very high complexity of medical decision making, such as a patient with 10 or more chronic conditions expected to last at least 12 months, or a patient on 10 or more chronic medications.
- Added complexity of medical decision making due to socioeconomic factors: Patient with specific identified family, lifestyle, or economic conditions contributing to higher intensity of care.

Finally, we also request codes that would recognize at least 20 minutes of the following services to complex patients, not requiring a face-to-face visit. Codes would be billed whether performed on the same day as E/M service or on a different day:

- Physician review and interpretation of validated questionnaires.
  - Note: Validated disease-specific questionnaires include rating scales for stroke, multiple sclerosis, Parkinson’s disease, and many other conditions.

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Validated quality of life questionnaires are useful for most chronic care patients. The use of validated scales is also increasingly important for quality monitoring purposes.

- Physician review, interpretation, and discussion of lab results or imaging studies. This would include patient instructions, dosage adjustments as needed, and ordering of additional tests.
  - Note: Shorter time for these services is included in the postservice work of E/M. This code can be structured similar to anticoagulant management, CPT Codes 99363 and 99364.

Finally, the AAN strongly supports the payment for interprofessional telephone/internet consultative services (CPT codes 99446-99449).

C. CCM and TCM Services

The AAN is also in agreement with proposed language expanding chronic care management (CCM) and transitional care management (TCM). The medical neighborhood concept recognizes that there are complex relationships among treating physicians. For example, a neurologist may provide a patient ongoing services on an occasional basis at the request of a primary care provider; but the neurologist may become the primary or lead physician during a period of acute or chronic illness, as during the first months after a stroke, or during a progressive illness such as ALS. We believe that Medicare beneficiaries should be able to specify a principal physician and change that designation when their health needs change. The work of providing CCM and TCM must include the time and resources necessary to explain new care models to patients and to ensure they are afforded an informed choice.

Furthermore, the AAN supports the payment for related CPT codes such as the complex care coordination codes (CPT codes 99487-99489). We believe there are numerous other services that CMS should recognize and implement separate payment beginning January 1, 2016, including: Anticoagulant Management (CPT Codes 99363 and 99364); Education and Training for Patient Self-Management (CPT Codes 98960-98962); Medical Team Conference (CPT Codes 99366-99368); Telephone Services (CPT Codes 99441-99443 and 98966-98969); and Analysis of Computer Transmitted Data (CPT Code 99091).

The AAN agrees with CMS that documentation for CCM and TCM services should be simplified. We do not support a specific technology requirements for interprofessional services or remote consultative services. Added technology requirements may disadvantage small and rural practices where remote services are needed.

II. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

MACRA-related regulations are poorly understood by physicians and affected patients. The AAN applauds CMS’ appeals for input from stakeholders. We understand that CMS will

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develop alternate sources of data regarding the structure of health care delivery and interprofessional consultations in APMs. We ask that CMS allow public access to its databases and that CMS demonstrate how it has relied on these data to make important decisions.

AAN is concerned about CMS’ proposal to report measure-level benchmarks derived using the Achievable Benchmark of Care (ABC) methodology. CMS proposes to use the methodology to systemically build a 5-star rating of eligible professionals and group practices that would be publicly reported. Stakeholders have previously noted the ABC methodology has been published only as a tool for internal benchmarking. It has not been validated for public reporting on the massive scale of the Physician Compare website. If CMS is to use this method in a new way, we request public access to the agency’s database and clear demonstration of its validity for this use.

**A. Low-Volume Thresholds**

The AAN is not aware of any data on the appropriate basis for the determination of a low-volume threshold, but we agree a minimum is appropriate. **We recommend providers should be excluded from Merit-Based Incentive Payment System (MIPS) penalties if less than 10 percent of their patients are CMS patients that can be attributed to that physician.** Additionally, there should be no MIPS-related adjustment if the physician had less than 100 eligible Part B encounters with patients, or if less than 20 patients are attributed to them. MIPS adjustments should be based solely on prospective attribution—the list of patients the provider receives before the measurement year begins—regardless of whether the provider is part of a group that is participating in a higher-risk Medicare Shared Savings Plan. The AAN believes CMS should model its policies with the MIPS low-volume threshold off the thresholds found in other CMS programs like Meaningful Use and the Value-based Payment Modifier. The AAN is also concerned about the extent to which certain subgroups of neurologists like pediatric subspecialists may have sufficiently low Medicare patients, volume, and revenue, such that they are better off excluded from MIPS.

**B. Clinical Practice Improvement Activities**

The AAN is concerned that some group practices may not have the funding or staff to participate in all clinical practice improvement activities. The requirements for clinical practice improvement activities should be broad enough to allow successful MIPS participation by small groups and solos providers, where participation in APMs may not be feasible.

Furthermore, clinical practice improvement activities should be based on practice-level quality data focused on gaps in care and flexible enough to be tailored to the practice’s needs. We urge CMS to consider adopting validated quality improvement models such as the Plan-Do-Study-Act (PDSA) Worksheet.11 This process has proved successful for instructing academic medical staff in quality improvement. Any adopted system should also be

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consistent over time and physicians or practices participating in any particular improvement activity should be assured their participation will be accepted by CMS for many years.

CMS notes six types of practice improvement activities. We suggest that the agency make interval incentive payments for any single step taken by a provider, much as it provides staged payments for meaningful use of electronic health records. The AAN further recommends that CMS' Center for Medicare & Medicaid Innovation (CMMI) fund studies with four goals: (1) to develop disease-specific global and population-based outcome measures; (2) to develop specialty-specific care episode groups based on commercial clinical grouper software as modified by expert panels; (3) to standardize quality measures by including quality of life and patient experience of care; and (4) to define standard measures to be included in clinical registries that are not disease specific. We also believe that CMS should develop care episode groups, not disease specific groups, for the first month after hospitalization for chronic disorders.

Additionally, CMS has proposed patient relationship categories. We recommend that CMS recognize these may change from month-to-month as detailed above. Patients or families should be able to revise their stated relationships with each physician as their health needs change, and physicians should be able to revise the care attributable to their own work as circumstances change.

As previously detailed, AAN recommends that CMS should support or develop codes to describe medical patients with unusually complex problems, similar to code 90785 for higher interactive complexity in psychotherapy. An expanded complexity scale is needed to address the needs of patients with multiple chronic illnesses and to adequately adjust case severity among physicians to determine cost-effectiveness of care.

On expanded practice areas, the AAN suggests that CMS pay for video telemedicine for same-day appointments for Medicare beneficiaries. For population management, the AAN recommends that more than half of patients with Alzheimer’s dementia should have appropriate treatment with acetylcholinesterase inhibitors. Furthermore, for the care coordination subcategory, the AAN suggests access to lab and radiology results at 72 hours for portal patients.

C. Alternative Payment Models

Due to the collaborative nature of the care required to diagnose, manage, and treat complex chronic neurologic conditions, APMs need to address payment for neurologists as well as other providers. While the AAN believes APMs are important, the lack of viable APMs for neurologists is troubling. As noted in an October 2014 report from the Brookings Institution, despite the proliferation of alternative care models addressing the needs of patient populations with dementia, epilepsy, multiple sclerosis, traumatic brain injury, and complex
headaches, there are currently no APMs implemented with a specific focus on complex chronic neurologic conditions.\textsuperscript{12}

The report describes key considerations for patients with these conditions, such as the importance of caregiver involvement, greater coordination for individuals with cognitive decline, and the inclusion of a variety of therapy services. Many enhanced care services needed for neurologic conditions are similar to those for patients with other chronic diseases, including care coordination and medical management. Successful APMs that support improved care for other chronic diseases may possibly be applied to support neurologic conditions as well.

APMs for complex chronic neurologic conditions need to address payment for neurologists as well as other providers. The report illustrates the example of an add-on-type payment with the potential to incentivize coordination of care between specialty providers. In this example, neurologists would receive a payment specifically for enhanced disease management, including collaboration with other providers.

It is possible beneficiaries with advanced cognitive decline or multiple comorbid conditions may benefit from a more sophisticated patient-centered medical home model.\textsuperscript{13} A neurologist in this type of APM would act as part of a complex care management team and share in the payments given to support the collaborative effort. In other cases, an episode-based payment model could be applied to some interventions, particularly with epilepsy patients.

The AAN is also concerned about geographic differences between these approaches, as certain APM opportunities may exist in only one part of the country or in cities, rather than rural practice areas. With these differences in mind, we strongly urge CMS to consider a regulatory framework that prioritizes flexibility for physicians whenever possible as the agency develops and implements MACRA-related regulations. The lack of APMs for neurologists and the difficulty of creating models appropriate for a diversity of practice settings highlights this need. A one-size-fits-all approach runs contrary to the goals of innovation and improving the quality of patient care.

The Brookings Institution’s report concludes that extensive evidence on alternative care models developed in complex chronic neurologic care suggests that APMs for neurologists could lead to improvements in care. Developing and implementing sustainable APMs for patients treated by neurologists is therefore a critical element of the broader effort to improve health care outcomes and control costs. We implore CMS to consider the lack of current APMs for neurologists as the agency further develops regulations in this area.


\textsuperscript{13} Homonoff, MC; et al. “The Neurologist as a Medical Home Neighbor.” Neurology Clinical Practice. 3.2 (April 2013): 134-140.
III. Improving the Valuation and Coding of the Global Package

In the CY 2015 MPFS final rule, CMS finalized a policy to transition all 10-day and 90-day global codes to 0-day global codes. Section 523 of MACRA prohibits the Secretary from implementing this policy and instead requires CMS to gather information needed to value surgical services from a representative sample of physicians. In the 2016 MPFS proposed rule, CMS requested comments on how to collect this data.

The AAN believes CMS should move quickly to implement the data collection process for surgical services and revalue surgical services based on that data, as required by MACRA. CMS should identify the specific sources of data it uses to measure or estimate the times for preservice, intraservice, and postservice surgical procedures. The databases should be open for public review and audit. Data-based valuation of surgical services will benefit all specialties and promote fairness across the Fee Schedule.

The documentation requirements and practice expenses for postoperative visits during the global period are different from those for other E/M visits. The AAN advises CMS to encourage and develop a separate series of codes to capture the work of these services and to measure, not just estimate, the number and complexity of visits during the global period.

IV. Advance Care Planning Services

The AAN strongly supports the payment for advance care planning (ACP) codes. ACP services are common in neurologic practice. Neurologists manage many disorders that may ultimately be fatal or possibly lead to a loss of function. Neurologists often discuss care planning not only with patients, but also with family and other caregivers.

ACP is a distinct, usually prolonged service that may occur on the same day as an E/M visit, but the patient may wish to schedule the ACP visit at a later date, so family members and caregivers can accompany them to the ACP appointment. The care plan may be revisited and revised as circumstances and disease severity change. ACP should be reportable as a separate service that may be performed on the same day as an E/M service, or at the time of a separate visit.

Patients who have had ACP conversations with their providers and families are more likely to receive the care they want. Despite the positive evidence in favor of ACP, the likelihood that an individual has completed an advance directive varies. According to a recent report, only 26.3 percent of adults have completed an advance directive. The report notes that the lack of awareness was the most common reason a patient did not have an advance directive.

The AAN also urges CMS and agency contractors to include these codes in the final 2016 rule as a national policy applicable to all Medicare beneficiaries regardless of their locality.

V. Refinement Panel

CMS is proposing to permanently eliminate the refinement panel and instead publish the proposed rates for all interim final codes in the MPFS proposed rule for the subsequent year.
The AAN supports this change because the opportunity to provide comments and receive responses in writing is more valuable than the current process of the refinement panel. We are additionally supportive because the publication of the proposed rates for all interim final codes promotes transparency in the regulatory process.

VI. Clinical Labor Task: Complete Botox Log

CMS states there are several codes with minutes assigned for the clinical labor task called “complete botox log” and the agency does not believe the completion of such a log is a direct resource cost of furnishing a medically reasonable and necessary physician service. The agency is proposing to eliminate the minutes assigned for the task “complete botox log” from the direct PE input database.

The AAN disagrees with this recommendation based upon the following rationale. Botulinum toxins come in 100 unit vials that are opened and used same day with patient dosage varying between 2 to 600 units. Both units used and wasted are billed. For example, if during one encounter a patient is dosed 50 units, they are billed for 100 and their chart documents 50 used and 50 wasted. This is documented in the record, in addition to the botulinum toxin log that tracks bottles and patients for each day. Practitioners are instructed by several Medicare Administrative Contractors to schedule patients in such a way so that the drug may be used most efficiently. Documentation must reflect the exact dosage of the drug given and a statement that the unused portion of the drug was discarded.

VII. Valuation of Specific Codes: Vestibular Caloric Irrigation (CPT Codes 9254A and 9254B)

The AAN is disappointed to see that CMS did not accept the RUC recommended values for CPT codes 9254A and 9245B, opting instead to reduce those values and assign work RVUs of .60 and .30 respectively. CMS assigned the work RVU of .60 based on a direct crosswalk to CPT code 97606 (Negative pressure wound therapy, surface greater than 50 square centimeters, per session) to CPT code 9254A. To value CPT code 9254B, CMS divided the proposed work RVU for 9254A in half (.30).

We object to CMS’ rationale regarding the valuation of 9254A and 9254B, as this rationale ignores the cogent, methodical, and thorough RUC approach utilized to review CPT codes. The AAN believes that the RUC approved work RVUs for 9254A and 9254B were reasonable and appropriate. We also believe that there are inherent flaws in selecting CPT code 97606 as a direct crosswalk for 9245A. This CPT code does not accurately capture the work and intensity of the service, and is not reflective of the work RVU supported by the survey data. CMS has chosen to crosswalk values to CPT code 97606, which was last valued in 2003. CMS now routinely requests RUC re-valuation of codes after five years or more, and CMS is not consistent in using a 12-year-old valuation as a crosswalk.

The AAN would like to suggest alternative crosswalk codes that more accurately and appropriately reflect the work and intensity of CPT code 9254A, such as 93015 and 95938, both of which were valued in 2012. We strongly support the RUC recommended work RVU of .80 for 9254A and .55 for 9245B. The AAN strongly disagrees with CMS’
decision not to accept the RUC recommendation for CPT codes 9254A and 9254B and we ask that CMS reconsider this decision within its final rulemaking for CY 2016.

VIII. Physician Compare

The AAN supports the decision to add the physician payment and utilization data to the downloadable database as opposed to the consumer-focused website profile pages. The Academy is also in favor of publicly reporting measures that CMS uses to pay physicians and other providers, including quality and cost data along with value modifiers.

With regard to potential quality measures, including composite measures, for future posting that may help consumers and stakeholders monitor trends in health equity, we believe it is important to emphasize that these measures would be largely not specific to a specialty practice like neurology and, therefore, may be misleading. The Academy believes that any provided scores should be placed in a context of national, regional, and ideally specialty-specific mean scores on the consumer site.

IX. Physician Quality Reporting System

The AAN supports CMS’ proposal to add new measures to the Physician Quality Reporting System (PQRS) program: (1) Chronic Opioid Therapy Follow-up Evaluation; (2) Documentation of Signed Opioid Treatment Agreement; (3) Evaluation or Interview for Risk of Opioid Abuse; (4) Overuse of Neuroimaging for Patients with Primary Headache and a Normal Neurologic Examination; (5) Quality of Life Assessment for Patients with Primary Headache Disorders.

The AAN is supportive of CMS’ proposal to add these five neurology measures to the PQRS program for the 2016 performance year. The National Quality Forum (NQF) has not had a call for neurology measures for several years; however, the AAN has continued to develop new measures. The AAN requests that CMS include these measures in the final rule, particularly given that neurologists currently have fewer than nine applicable measures.

The AAN supports CMS’ proposal to add the measures for cognitive impairment assessment among at-risk older adults, and documentation of a health care proxy for patients with cognitive impairment. These are both from a report commissioned by NQF which recommends the assessment for mild cognitive impairment in at-risk older adults. CMS should consider specifying a tool to use for the assessment. The AAN also supports the new health care proxy measure, in which the denominator is people with a diagnosis of dementia.

Further, CMS has proposed to remove from PQRS measure #33, Stroke and Stroke Rehab/Anticoagulant therapy prescribed for atrial fibrillation at discharge. The AAN disagrees with the CMS rationale that this measure is duplicative of another stroke measure. PQRS measure #32 denominator is sufficiently different than PQRS measure #33

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denominator. Measure #32 was created to ensure that a subset of stroke patients with
documented permanent, persistent, or paroxysmal atrial fibrillation were prescribed
anticoagulants, and given the known risks of atrial fibrillation the AAN encourages
continued use at this time.

CMS also proposes to remove Dementia: screening for depressive symptoms, for which the
AAN and the American Psychological Association (APA) are the measure stewards. CMS
claims this is duplicative with another measure of prevention and screening for depression.
The AAN recommends that if CMS removes the screening measure, then the screening tool
for depression must have a scale that is applicable to patients with dementia. If the current
measure for screening for depression is valid for dementia then the AAN would support the
proposal to remove the other measure.

CMS has also proposed changes to the Dementia measures group (Table 29B in the rule).
PQRS measure 134 reads: “Percentage of patients aged 12 years and older screened for
clinical depression on the date of the encounter using an age appropriate standardized
depression screening tool and if positive, a follow-up plan is documented on the date of the
positive screen.” The AAN modeled its MS depression measure after this and we support the
model. However, we also believe it should be dementia appropriate.

The AAN additionally supports the CMS proposal that recognizes that skilled nursing facility
(SNF) patients are shorter stay patients than nursing facility patients and are generally
receiving continued acute medical care and rehabilitative services. CMS notes that while
their care may be coordinated during their time in the SNF, they are then transitioned back in
the community to their primary care physician. The proposal excludes services billed under
CPT codes 99304 through 99318 when the claim includes the place of service (POS) 31
modifier indicating the patient is in a SNF.

Finally, the AAN supports the CMS proposal that both PQRS and non-PQRS measure
reporting by a Qualified Clinical Data Registry (QCDR) be reported publicly starting with
2015 data. This data will be reported for individual eligible professionals (EPs) for any
measures that have been collected for at least a full year. CMS also proposes to add group
practices’ reporting via QCDR to the website, provided that the measures have been
collected for at least a year.

X. Value-Based Payment Modifier

The AAN supports the proposal to assign practices for the Value Modifier (VM) the highest
score they received among multiple ACOs. Additionally, the AAN supports the proposal to
waive the VM payment adjustment if at least one EP in the tax identification number (TIN)
participated in the Pioneer ACO Model or similar models. We additionally support the
waiver of the VM for EPs who participate in the Next Generation ACO, the Oncology Care
Model, and the Comprehensive ESRD Care Initiative. Both proposals are aligned with the
goals set by MACRA of incentivizing physicians to join APMs. However, the AAN requests
CMS accelerate its work defining APMs for specialties like neurology.

The AAN is also concerned with the comparability of physicians’ score on the VM based on
the reporting option. Physicians who are part of large health care systems or multispecialty
group practices typically have minimal control over which reporting option is available to them. If the only applicable measures for an EP are reported via a specialty-specific registry, but the EP belongs to a large group that will be reporting via Group Practice Reporting Option (GPRO) electronic health records, then the specialty-specific measures may not be available for the EP to report. The AAN also has concerns regarding the availability of reporting options for neurologic quality measures, because neurologists have little control over the electronic health records that they have in their practices.

The AAN supports the proposals to give EPs the opportunity to correct mistakes on their QRUR and to hold EPs harmless for errors made by a vendor. We also support the proposal to increase the episode minimum, as it will make the VM less susceptible to bias from small sample sizes.

**XI. Medicare Telehealth Services**

The AAN’s position is that restrictions should not be put into policy based on geographic areas. Additionally, the rules for the remote site produce unique challenges for neurology. Providing necessary personnel to facilitate a teleneurology consultation is different than other specialty areas. Neurologists often need another person, usually a nurse, to facilitate the exam. The obligations should be clear for receiving the transmitting remote site technical fee.

Furthermore, we believe there should be an ability to bill based on time spent. Neurologic exams and consultations are more time consuming than others and billing for the time versus the consultation codes would make it more feasible to complete. Requirements for neurologic billing are cumbersome in terms of documentation and it becomes difficult to bill at the highest levels for complex teleneurology consultations because neurologists cannot complete all of the necessary exam elements required by the current system. For critical care billing such as stroke and epilepsy, it is difficult to be adequately compensated for the work done using consultation codes as they currently exist.

**XII. Incident-to Billing**

CMS proposes changes to the “incident-to” regulation governing Medicare payment for services performed by qualified auxiliary personnel under the supervision of a physician or non-physician practitioner (NPP). There is some confusion regarding the removal of the last sentence of the regulation which currently provides that the physician or NPP “supervising the auxiliary personnel need not be the same physician upon whose professional service the incident to service is based.” The deletion of this language leads to confusion about whether the ordering physician or NPP must also be the supervising physician or NPP to bill for the incident to services.

However, the AAN is aware of communication from CMS after the proposed rule was published that indicates the revisions were intended to clarify that the ordering and supervising physician and NPP do not need to be the same person. We want to stress the need for CMS to clarify this regulation to accurately capture the agency’s intended policy.
XIII. Appropriate Use Criteria for Advance Diagnostic Imaging Services

The AAN supports CMS’ decision to implement Appropriate Use Criteria (AUC) for advanced diagnostic imaging services. However, the CMS proposal has the potential to add additional challenges to physician workflow and place administrative burdens on smaller practices. **The AAN recommends that if CMS implements AUC, it be done through the requirement of a clinical decision support mechanism that is fully integrated within the Certification Commission for Healthcare Information Technology certification criteria for electronic health records.** Additionally, appropriate use could be better codified. There should be a table of appropriate ICD-10 codes that are associated with the CPT.

XIV. Physician Self-Referral Updates

CMS is proposing an exception for non-physician recruitment assistance that permits payments by hospitals, federally qualified health centers, and rural health centers to physicians to assist with the employment of non-physician practitioners. The proposed exception stems from current primary care workforce shortages. CMS’ proposed exception for non-physician recruitment applies only where the non-physician practitioner is a bona fide employee of the physician receiving the remuneration, and the purpose of such non-physician practitioner’s employment is to only provide primary care services to the physician’s patients.

The AAN reminds CMS that neurologists often serve as the primary care provider for their patients. Additionally, neurology, like primary care, faces workforce shortages. As the incidence of Alzheimer's disease, Parkinson’s disease, and other neurologic diseases linked to aging soars, the number of neurologists available to manage them is not growing apace.15 As such, there is a need for non-physician practitioners in neurology practices.

XV. Conclusion

We greatly appreciate this opportunity to share the views of the AAN regarding the proposals, issues, and questions that CMS has raised in the Proposed Rule. If you should have any questions regarding this letter, please contact Daniel Spirn, Regulatory Counsel for the AAN, at dspirn@aan.com or (202) 525-2018.

Sincerely,

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology

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